Appendix 41i ▪ Nurse Care Manager/ Social Work Care Manager Recommended Orientation Checklist

Job Function	Cannot Perform/ Needs Training*	Performs with Minimal Supervision	Performs Independently
	*Supervisor needs to complete the Social Work Care Manager/Nurse Care Manager Training and Development Plan. If skill does not apply, please indicate N/A.		
DEMONSTRATES THE ABILITY TO:			
1. Screen clients for eligibility and appropriateness for MSSP participation.			
2. **NCM only:** Certify level of care (LOC) determinations.			
a. Complete the LOC certification form with rationale and justification to substantiate the LOC determination.			
b. Sign and date all entries on the LOC certification form.			
c. Check the appropriate box to indicate home visit or record review.			
d. Re-certify client's LOC at no greater than twelve-month intervals.			
e. Re-establish eligibility as it relates to LOC.			
3. Complete application form and inform clients of:			
a. Circumstances under which he/she will lose services.			
b. The client grievance procedure.			
c. Termination procedures.			
d. Any other information deemed essential for the proper delivery of services.			
4. Confirm and document the client's perception of why he/she was referred to the program, how he/she characterizes his/her situation and needs, and verify client's choice to participate in MSSP.			
5. Complete the Authorization for Use and Disclosure of Protected Health Information forms.			
6. Conduct in-depth assessments appropriate to the discipline, adequately addressing all elements, within two weeks of enrollment. Conducting assessments involves:			
a. Face to face interview with the client,			
b. Contact with family and other informal supports, if appropriate.			
c. Contact with client's physician and other health providers, as appropriate.			

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7. Assessment elements include, as appropriate to discipline:			
a. Medical history.			
b. Health history.			
c. Psychosocial history.			
d. Rehabilitation history/needs.			
e. Functional Needs Grid.			
f. Cognitive Status Exam.			
g. Medications List.			
h. Health Professional List.			
i. Re/assessment Summary.			
j. Problem list.			
8. Critically identify the assessment outcome to include:			
a. The client's functional capacity to live independently.			
b. The system, if any, that supports independent functioning.			
c. What more is needed to sustain as much independence as possible.			
d. Situations where the client is at risk.; e.g., safety, abuse, neglect, depression, other psychosocial and/or health factors.			
9. Conduct quarterly face-to-face visits and monthly contacts to include:			
a. Identification of changes in client's situation warranting care plan changes.			
b. Identification of safety risks.			
c. Identification of physical, fiduciary, exploitative abuse.			
d. Identification of immediate health/medical risks, including those of a pharmacological nature.			
e. Identification and provision of education to client and family.			
10. Consult and work closely with others involved with the client, including collateral agencies, physician, pharmacists, consultants, IHSS, APS, and others.			
11. Make intervention/service arrangements.			
12. Provide justification, obtain authorization, and implement services.			

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13. Monitor service delivery and client's use of service(s).			
14. Monitor client's situation to ensure that services continue to meet the client's needs.			
15. Appropriate consultations between Social Work Care Manager and Nurse Care Manager; client seen by both disciplines at least annually.			
16. Review records pertaining to clients' situation, conditions, services.			
17. Perform case recording by:			
a. Documenting all case management activity.			
b. Including entries at least monthly.			
c. Including type of contact with client or other identified individual.			
d. Recording all events that affect the client.			
e. Including evaluative comments on services delivered.			
f. Including comments on the relationship between identified problems and services delivered or not delivered.			
g. Documenting all contacts with collateral agencies, physician, pharmacists, consultants, IHSS, APS, and others.			
h. Ensuring that notes are dated and signed.			
i. Ensuring that notes follow MSSP standards of documentation.			
j. Verifying applicant's choice to participate in MSSP.			
k. Verifying the necessity and appropriateness of MSSP services, including the need for care management.			
l. Reflecting monitoring and follow-up of services.			
m. Verifying services delivered.			
n. Reflecting the timeliness and effectiveness of services.			
18. Report to other professionals/agencies as appropriate.			
19. Share information across disciplines and act as a consultant in the care manager's area of expertise.			
20. Conduct a complete reassessment at least annually in client's place of residence. Reassessment activities include:			

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a. Completion of the Reassessment tool.			
b. Analysis of changes during the period since last assessment.			
c. Assurance that client's needs are being met.			
d. Assurance that increases, additions, augmentation, decreases, reductions or termination of services are addressed.			
21. Develop and write a care plan that is consistent with MSSP policies, reflects client's medical, physical and psychosocial needs. Elements include:			
a. Problem statements.			
b. Goals.			
c. Specifies plan for intervention.			
d. Specifies name and type of service (I-R-P-C).			
e. Comments/outcomes or resolution of problem.			
f. Considers the client/caregiver's wishes.			
g. Includes the client rights to a fair hearing.			
h. Includes the primary care manager's signature.			
i. Includes supervising care manager's signature.			
j. Ensures that the client signs the care plan within 90 days.			
k. Ensures that services are listed on the SPUS.			
l. Revisions as necessary to reflect changes in the client's situation.			
22. As appropriate, develop and write a risk management plan which reflects:			
a. A description of the situation.			
b. An explanation of the cause(s) of concern.			
c. The possible negative consequences to the client and/or others.			
d. A description of the client's preference.			
e. Possible alternatives/interventions to minimize the potential risk(s) associated with the client's preference/action.			

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f. A description of the services, if any, that will be provided to accommodate the client's choice or minimize the potential risk.			
g. The final agreement, if any, reached by all involved parties.			
23. Determine when a notice of action is required, and the process and time frames for the action.			
COMMENTS:			